Do NOT write in this space.

State of Colorado COBRA Election Form

NOTE: You have 60 days to elect to continue your current coverages through COBRA.

State of Colorado
Department of Personnel & Administration

PARTICIPANTS

Emp. Social Security #:	Emp. Last Name	Emp. First Name	M.I.	Home Phone	Dept. Name

Home Address	City	State	Zip Code	County	Work Phone	Agency Org. ID

LIST ALL PERSONS TO BE COVERED UNDER COBRA

	LAST NAME	FIRST NAME	MI	CHECK ONE	DATE OF BIRTH MM/DD/YY	SOCIAL SECURITY #	CONTINUE... MEDICAL	CONTINUE... DENTAL	CONTINUE... FSA	Enrolled in Medicare	* Other Insurance Coverage is For... MEDICAL	* Other Insurance Coverage is For... DENTAL
Emp.				☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Spouse				☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dep-1				☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dep-2				☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dep-3				☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dep-4				☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

PLAN, QUALIFYING EVENT/DATE, COVERAGE LENGTH

Enter name of current medical plan:	If leaving current medical coverage area, enter name of new medical plan:	Enter name of current dental plan:	Are you electing COBRA because your **new employer** has a preexisting condition limitation clause for medical and/or dental? Yes, for: ☐ Medical ☐ Dental	**NOTE:** COBRA coverage ends when the preexisting limitation with new employer has been satisfied.

Other Coverages:** Are you or any of your covered dependents covered by another ***medical plan? ☐ No ☐ Yes If yes, complete below:

Person covered:	Plan Name:	Plan Number:
Person covered:	Plan Name:	Plan Number:

Qualifying Events, Length of Coverage, and Qualifying Event Date

You and your covered dependents whose current medical and/or dental coverage would otherwise terminate due to certain events called "qualifying events" may elect to continue coverage for yourself and your qualified dependents.

Check the qualifying event that applies:	***Total Months of Coverage Eligibility***	***Qualifying Event Date***
☐ Termination of employment/retirement	18 months	
☐ Disability Retirement/Termination	29 months (Proof of disability required)	
☐ Reduction of work hours	18 months	
☐ Death of employee	36 months	
☐ Divorce or legal separation	36 months	
☐ Employee electing Medicare as primary	36 months (affects dependents only)	
☐ Child losing eligibility	36 months	

FOR AGENCY USE ONLY:

Date of Qualifying Event _____

Date Current Coverage Ends _____

FOR EMPLOYEE BENEFITS USE ONLY:

COBRA Eligibility Begins _____

COBRA Eligibility Ends _____

Medical/Dental Billing Begins _____

FSA Billing Begins _____

Medical GTN _____

Dental GTN _____

Sent to Carrier(s) _____

SIGNATURE(S)

COBRA Statements & Signature (MUST be signed and dated)

It is understood and agreed that the above information is true and shall be the basis for the issuance of the coverage(s) applied for, and that the omission or misstatement of any material information shall void this application for coverage. I/We authorize, by my/our signature(s), any physician, hospital, clinic or other organization or person to release to the appropriate medical and/or dental provider(s) or its representative(s), all medical and/or dental records which the latter may require for the purpose of evaluating the delivery of alternative methods and utilization of health care services appropriate to any health condition. I/We further agree that my medical and/or dental carrier has the right to cancel my/our coverage in the event that I/We fail to cooperate in providing the company with these records or if I/We fail to pay the premium(s) within the required time period. **A photographic copy of this authorization shall be as valid as the original.** I/We hereby certify that I/We have read the conditions on the reverse side of this COBRA Election Form and that I/We understand the terms of this coverage.

Employee Signature _____ Date _____

Signature: (Check one) ☐ Spouse ☐ Former Spouse Date _____
(Must be signed if applying for coverage on his/her own)

Dependent Signature _____ (Date) _____
(Must be signed if applying for coverage on his/her own)

(Rev. 2-20-2004)

Distribution: Please make and retain a copy of this form. Submit the original to Employee Benefits Unit COBRA Coordinator (address on

COBRA Election Form Instructions

Before completing this application for continuation of coverage(s), you must review the booklet which describes your COBRA rights, the regular monthly rates, and if disabled, the disabled monthly rates (which start on the 19th month of COBRA coverage). If you have not been provided a copy of the booklet, contact your agency payroll or personnel administrator immediately. The booklet includes a description of your filing requirements and the reasons under the law that your coverage may be discontinued. Do not complete this form until you fully understand your rights and responsibilities under the law.

HOW TO COMPLETE THIS FORM:

- The first two rows is for the employee only.
- List all eligible persons to be covered under COBRA.
- Check yes or no for each individual electing "medical", "dental", "FSA" (Flexible Spending Accounts for employee only), if "Enrolled in Medicare," and if other insurance coverage is for "medical" and "dental."
- Enter the name of your current medical plan.
- If you are moving out of the coverage area of your current medical plan, you must select a new medical plan. Check the appropriate box next to your new medical plan.
- Enter the name of your current dental plan. NOTE: You may change dental plans ONLY during the annual open enrollment period.
- If you are electing COBRA continuation of coverage because your new employer has a preexisting condition clause for medical and/or dental, check the box(s) that apply.
- Select appropriate yes/no box if you or any of your dependents are covered by another medical plan. If yes, enter information on lines provided.

Qualifying Events/Date & Length of Coverage

- Check the qualifying event that applies to your situation. The number of corresponding months of eligibility are located next to the qualifying event. Enter the Qualifying Event Date on the line next to your Qualifying Event selection.

COBRA Statements & Signature

- Read this paragraph carefully.
- The spouse/former spouse, if applying for continuation of coverage on his/her own, must check the appropriate box (spouse or former spouse) then sign and date this form on the appropriate line.
- A dependent, if applying for continuation of coverage on his/her own, must sign and date this form on the appropriate line.
- Retain the yellow copy for your records. Return the white copy to:
  Department of Personnel & Administration
  1313 Sherman Street, Room 114
  Denver, Colorado 80203-2244

For More Information

If you are unsure of your rights and responsibilities under the law or need assistance in completing this form, contact the Department of Personnel & Administration COBRA Coordinator at 303-866-3434 or 1-800-719-3434.

Billing - Medical/Dental: After processing of your application for continuation of coverage(s) through COBRA, you will receive monthly billings directly from the appropriate medical and/or dental carrier(s). **Do not send medical and/or dental payments to the Department of Personnel & Administration (DPA)**.

Billing - Health Care Flexible Spending Account: If you elect to continue your Health Care Flexible Spending Account, you will not receive a formal bill. Payments for your current monthly countributions must be sent directly to:
Department of Personnel & Administration
1313 Sherman Street, Room 114
Denver, Colorado 80203-2244

Fraud

It is unlawful for any employee, employee's dependent(s) or other individual(s) to knowingly and intentionally provide false, incomplete, or misleading facts or information on any benefits enrollment form, affidavit, or other document for the purpose of defrauding or attempting to defraud the State of Colorado with regards to the application for benefits or claim for benefits. Penalties may include imprisonment, fines, denial of enrollment in any or all of the state's benefit plans, civil damages, termination of enrollment in any or all of the state's benefit plans, or as provided in regulations, statutes, and written directives.